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Office of Administrative Law Judges
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Issue Date: 13 June 2007

CASE NO. 2004-BLA-6548

In the Matter of

L.F.C.,
Claimant

v.

DAVIDSON MINING, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Otis R. Mann, Jr., Esquire
For the Claimant

Anthony J. Cicconi, Esquire
For the Employer

Before: STEPHEN L. PURCELL
Associate Chief Judge

DECISION AND ORDER-AWARDING BENEFITS

This proceeding arises from a claim for benefits filed by L.F.C., a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on August 7, 2003 (DX 4), the new regulations are applicable (DX 36).

to the surviving dependents of coal miners whose deaths were caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on March 31, 2006 in Beckley, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder. Furthermore, I held the record open to allow for the submission of post-hearing briefs (TR 23). In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 30 (DX 1-36), Claimant's Exhibits 1 through 5 (CX 1-5), and Employer's Exhibits 1 and 2 (EX 1-2).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On July 17, 1996, Claimant filed an application for Federal black lung benefits under the Act, which was denied by the Deputy Commissioner's office (now known as the District Director's office) on October 3, 1996 (DX 1, sub-exhibits 1, 11). Although Claimant filed a timely request for a formal hearing (DX 1, sub-exhibit 13), he failed to appear at formal hearings held on August 6, 1997 and July 1, 1998, respectively. Claimant filed a timely response to the initial Order to Show Cause. Accordingly, Administrative Law Judge Stuart A. Levin issued an Order Denying Motion to Dismiss and Continuing, dated September 9, 1997. However, Claimant's response to the second Order to Show Cause was not timely. Therefore, Administrative Law Judge Samuel J. Smith issued a Decision and Order Dismissal of Claim, dated July 29, 1998, in which the above-referenced claim was dismissed with prejudice (DX 1). Since Claimant did not appeal nor request modification of the dismissal within one year thereof, the above-referred claim is administratively closed (DX 1).

On March 20, 2001, Claimant filed another application for Federal black lung benefits. However, the District Director issued a Proposed Decision and Order denying benefits, dated May 30, 2002. Since the miner did not appeal nor request modification within one year of the denial, the above-referenced claim is also finally denied and administratively closed (DX 2).

On August 7, 2003, Claimant filed the current application for black lung benefits under the Act (DX 4). Subsequently, the District Director issued a Proposed Decision and Order awarding benefits, dated May 28, 2004 (DX 29). Following Employer's timely requests for a formal hearing (DX 30, 32), this matter was referred to the Office of Administrative Law Judges for *de novo* adjudication (DX 34-36). As stated above, a formal hearing was held on March 31, 2006, and the record was held open for the submission of post-hearing briefs (TR 23).

Stipulations and Issues

The Form CM-1025 transmittal sheet initially listed almost every conceivable issue as contested (DX 34). However, at the formal hearing, Employer withdrew numerous issues,

including: timeliness, miner, post-1969 employment, length of coal mine employment, [simple] pneumoconiosis, causal relationship, responsible operator, and insurance (TR 5-7).

The remaining contested issues are as follows:

I. Whether the miner has *complicated* pneumoconiosis as defined by the Act and the regulations.
II. Whether the miner is totally disabled.
III. Whether the miner's disability is due to pneumoconiosis.

(DX 34, as amended; TR 5-7).

Findings of Fact and Conclusions of Law

Background

A. Coal Miner and Length of Coal Mine Employment

The parties stipulated, and I find, that Claimant engaged in coal mine employment for 21 years (TR 5-6).

B. Date of Filing

Claimant filed the current claim for benefits under the Act on August 7, 2003 (DX 4). There is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. §725.308(c). This presumption has not been rebutted. Moreover, Employer no longer contests this issue (TR 6).

C. Responsible Operator

Employer, Davidson Mining, Inc., is the properly designated responsible operator in this case, under Subpart G, Part 725 of the Regulations (DX 5, 8; TR 6, 13-14).

D. Dependency

Claimant has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Willie Dolores (DX 4, 11; TR 20-22).[2]

E. Personal and Employment History

Claimant was born on July 14, 1941 (DX 4; TR 13). As stated above, Claimant has established one dependent under the Act, and that he engaged in coal mine work for 21 years. Claimant testified that he stopped working as a coal miner in 1992, when the mine shut down. His last usual coal mine job was as a roof bolter (TR 13-15). On the Description of Coal Mine

[2] Although Claimant testified that he also provides a majority of the support for two grandchildren, he has not adopted them. Accordingly, they are not his dependents under the Act and applicable regulations (TR 20-22).

Work and Other Employment form, Claimant stated that the job entailed the following daily physical activities: standing for 8 to 10 hours; crawling 4 to 10 feet; lifting 50-75 pounds 4 hours; and carrying 50 pounds (DX 7). At the hearing, Claimant stated that his roof bolter job involved working in various heights ranging "from 36 up to five and a half to six foot." The job entailed lifting at least 50 pounds or more on a daily basis (TR 14-15). After leaving the coal mines in 1992, Claimant worked in various non-coal mine jobs. He primarily worked as a security guard and cook, respectively (DX 8; TR 16, 19). Claimant also testified that he subsequently tried to find work as a coal miner in a union mine, but "it never panned out." (TR 19-20).

Claimant stated that he started having breathing problems in 1987, and that the condition has worsened over the years (TR 16). Dr. Hassan treats Claimant for his breathing difficulties. The medical treatment includes a breathing machine at home, a breathing pill taken three times per day, and, Floradil, which is "an inhaler in capsule form." (TR 17-18). Claimant has never smoked (TR 18).

Medical Evidence

The case file includes various chest x-ray readings, pulmonary function studies, arterial blood gases, and physicians' opinions, as summarized below.

A. Chest X-rays

The chest x-ray interpretations submitted in conjunction with the current claim are as follows:

Exhibit	Date	Physician	Classification	Quality
DX 13	10/13/03	Patel	1/0, A	2
DX 14	10/13/03	Binns	0/1, 0[3]	1
CX 1	10/13/03	Aycoth	1/1, A	1
DX 14	4/13/04	Gogineni	1/1[4]	---
CX 4	4/13/04	Miller	2/1	1

On the ILO classification sheet, Dr. Miller noted "0" large opacities. However, on his typewritten report, dated April 13, 2004, Dr. Miller stated, in pertinent part:

IMPRESSION:

Findings consistent with simple pneumoconiosis, category q/t, profusion 2/1.

[3] Although Dr. Binns initially reread the October 13, 2003 x-ray for film quality purposes only (DX 13), he subsequently provided a substantive interpretation (DX 14).

[4] Dr. Gogineni's x-ray report, dated April 13, 2004, was not on an ILO classification sheet. However, Dr. Gogineni reported "a 3 cm x 2 cm opacity along the second anterior interspace." On the other hand, Dr. Gogineni concluded: "IMPRESSION: Minimal changes compatible with pneumoconiosis. Right upper lobe mass suspicious for neoplasm. Suggest biopsy." (DX 14).

> 3 cm. large opacity right upper lobe: malignant neoplasm versus pulmonary fibrosis (complicated coal worker's pneumoconiosis category A). Recommend comparison with old films or get CT or follow-up chest x-ray (notify primary physician). Similar findings are described in written report of chest x-ray from 10/13/03, so that complicated coal worker's pneumoconiosis is favored over malignant neoplasm.
>
> Grade A bilateral pleural thickening, extent 1.
>
> Coalescence of small pneumoconiotic opacities (ax).

(CX 4). Moreover, in an addendum report, dated March 21, 2006, Dr. Miller stated, in pertinent part:

> Given the letter of 01/24/06 from Clinch Valley Medical Center describing the pathology results from FNA of right lung mass, the 3-cm. large opacity on chest x-ray from 04/13/04 clearly represents complicated coal worker's pneumoconiosis, <u>not</u> malignant neoplasm.

(CX 5).

All of the above-listed physicians are dual-qualified B-readers and Board-certified radiologists. Therefore, the relative qualifications of the above-named physicians is not a controlling factor in weighing the x-ray evidence.

Of the five x-ray interpretations in evidence, four are positive for *at least* simple pneumoconiosis under the classification requirements set forth in §718.102(b). Since Dr. Binns is the only physician who failed to even diagnose simple pneumoconiosis, I accord his interpretation less weight. Moreover, at the formal hearing, Employer stipulated to the presence of *simple* pneumoconiosis (TR 5). However, the crux of this case rests on whether Claimant has established the presence of *complicated* pneumoconiosis.

Of the four physicians who diagnosed x-ray evidence of simple pneumoconiosis, two clearly and unequivocally reported Category A large opacities on their ILO classification forms (*i.e.,* Drs. Patel and Aycoth). Moreover, as stated above, even though Dr. Miller reported "0" large opacities on the ILO classification sheet, his more detailed written report expressly set forth a finding of a "3 cm. large opacity right upper lobe" (CX 4). Moreover, Dr. Miller ultimately determined that the large opacity represented complicated coal worker's pneumoconiosis." (CX 5). Furthermore, as previously noted, even Dr. Gogineni found a "3 cm x 2 cm opacity." However, he thought it was "suspicious for neoplasm" (DX 14).

In summary, I accord little weight to Dr. Binns x-ray reading, because he failed to even diagnose simple pneumoconiosis. The four remaining B-readers and Board-certified radiologists not only diagnosed simple pneumoconiosis, but also described large opacities on their ILO classification sheets and/or in their written reports. Moreover, the majority of them expressly diagnosed complicated pneumoconiosis (DX 13; CX 1; CX 4-5; *Compare* DX 14). Accordingly,

I find that Claimant has met his burden of establishing the presence of *complicated* pneumoconiosis by a preponderance of the x-ray evidence.

B. Biopsy Evidence

On or about May 18, 2004, Claimant underwent a "needle aspiration" of the "lung, right upper lobe" at the Beckley – ARH Hospital (DX 15). In an unsigned report, dated May 19, 2004, which apparently was dictated by Dr. Fausto Imbing, Jr., the amount and/or description of the biopsy sample was listed as follows: "3 pieces black tissue and approximately 2 cc blood tinged fluid." Furthermore, the following interpretation was noted: "Fibrosis and anthracotic pigment deposits" and "Negative for malignancy." (DX 15).

Dr. Richard L. Naeye, who is Board-certified in Anatomic & Clinical Pathology (EX 2), issued a report, dated January 13, 2006, in which he reviewed the above-referred biopsy specimens (EX 1). Regarding his biopsy findings, Dr. Naeye stated, in pertinent part:

> I have reviewed the microscopic findings in tissues on this slide under both normal and polarized light. There are 6 serial sections of at least 3 pieces of tissue on the slide. None show findings that clearly indicate it came from a lung. It could have been a lymph node. Assuming it came from a lung, no lesion reaches 1 cm in any diameter. The largest piece of tissue is 2-3 mm in its greatest measurement. Microscopically, a very old disease process is present, likely comprised of several even older lesions that grew together. Black pigment, where present, is accompanied by a moderate number of birefringent crystals, only a few of which are tiny enough to be toxic fibrogenic silica. There is no evidence of any recent fibrogenesis in the lesions. They are many years old.

(EX 1).[5]

Dr. Mario Stefanini is Board-certified in Pathology, with sub-certifications in Clinical Hematology, Clinical Pathology, Anatomic Pathology, Medical Chemistry, and Blood Banking. In addition, Dr. Stefanini is Board-eligible in the fields of Internal Medicine and Nuclear Medicine (EX 3). In a report, dated January 24, 2006, Dr. Stefanini stated that he had received Dr. Imbing's pathology report regarding Claimant's histological slide of the right upper lung. Furthermore, Dr. Stefanini reviewed the slide, which contained three small sections of tissue, and stated, in pertinent part:

> The sections show uniform appearance. Within a matrix of fibrotic tissue are numerous deposits of black stained pigment. There is single arteriolar vessel showing subintimal hyperplasia of wall.
>
> It would appear that this product of fine needle aspiration was obtained from a fibrous mass stated to be in the upper lobe of the right lung. Findings are consistent with product from a macula of coal workers' pneumoconiosis. The extent of the process cannot be

[5] A further discussion of Dr. Naeye's opinion is set forth under the "Physicians' Opinions" section of this decision. In that section, I address Dr. Naeye's overall analysis of the available medical evidence, including both biopsy and non-biopsy evidence.

judged from this specimen alone, but it would appear that the mass was 2 ½ to 3 cms. Also it would appear that chest X-ray findings were of coal workers pneumoconiosis. Histological findings go along with this diagnosis.

(CX 3).

In summary, Dr. Imbing's biopsy interpretation of "fibrosis and anthracotic pigment deposits" and Dr. Naeye's findings of black pigment with a moderate number of birefringent crystals, including a few which are indicative of toxic fibrogenic silica, tend to support the finding of pneumoconiosis. Furthermore, Dr. Stefanini expressly stated that the histological findings are consistent with the chest x-ray findings of coal workers pneumoconiosis. However, as previously stated, the Employer has stipulated to the presence of simple pneumoconiosis. On the other hand, I find that the biopsy evidence, in and of itself, does not establish complicated pneumoconiosis. The biopsy was described as a "needle aspiration" by Dr. Imbing; and, Dr. Naeye reported that the "largest piece of tissue is 2-3 mm in its greatest measurement." In fact, Dr. Naeye was not even sure whether the biopsy specimen came from a lung or a lymph node. Finally, as stated above, Dr. Stefanini stated that "the extent of the process cannot be judged from this specimen alone, but it would appear the mass was 2 ½ to 3 cms." Although this may be suggestive of complicated pneumoconiosis, in conjunction with Dr. Stefanini's other findings, it is ambiguous. In view of the foregoing, I find that the biopsy evidence neither precludes nor establishes the presence of complicated pneumoconiosis.

C. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains a pulmonary function study, dated October 13, 2003 (DX 13), which is not qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. Accordingly, the pulmonary function study evidence does not establish a total (pulmonary or respiratory) disability.

D. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes an arterial blood gas study which was administered on October 13, 2003 (DX 13), which is not qualifying under the applicable criteria set forth in 20 C.F.R. Part 718, Appendix C. Therefore, Claimant has failed to establish a totally disabling pulmonary or respiratory impairment based upon the arterial blood gas study evidence.

E. Physicians' Opinions[6]

In addition to the medical reports outlined above which address the x-ray and biopsy evidence, the record contains CT scan interpretations (DX 9; CX 2, 3) and the reports of Drs. Rasmussen (DX 13) and Naeye (EX 1), respectively.

The CT scan, dated April 13, 2004, was initially read by Dr. Ravindra K. Gogineni, a B-reader and Board-certified radiologist (DX 14). In summary, Dr. Gogineni stated:

> IMPRESSION:
> 1. Minimal interstitial changes. Right apical scarring.
> 2. A 3 x 2 cm irregular mass in the right upper lobe is suspicious for neoplasm. There is a mediastinal and right axillary adenopathy. A calcified granuloma is also seen in the right upper lobe. No pleural pathology is seen. Comparison with prior studies if available should be made, if not a biopsy advised for further evaluation of the right upper lobe mass, since neoplasm is strongly suspected.

(DX 14).

The CT scan, dated April 13, 2004, was reread by Dr. Edward Aycoth, a B-reader and Board-certified radiologist (CX 2). In his report, dated October 6, 2005, Dr. Aycoth noted Claimant's clinical history of approximately 20 years as a coal miner, as well as Claimant's nonsmoker status. Furthermore, Dr. Aycoth reported the following pertinent findings: a 2 ½ x 3 cm. right upper lobe mass; scattered round density opacities throughout both lungs; and large opacities measuring over 10 mm. in width. In summary, Dr. Aycoth stated:

> IMPRESSION:
>
> Complicated pneumoconiosis category A, 1/1, p/q.
>
> There is a prominent 2 ½ to 3 cm. right upper lobe mass density effect. Cannot rule out neoplasm on single exam and suggest old films for comparison. Inform personal physician.

(CX 1).

Dr. Donald L. Rasmussen, who is Board-certified in Internal Medicine and Forensic Medicine, examined Claimant on October 13, 2003 (DX 13). In his report on that date, Dr. Rasmussen set forth the miner's subjective complaints, which included shortness of breath with exertion; past medical history; review of systems; habits; medications; family history; and, occupational history, which included about 20 years of work in the coal mining history ending in 1992. On physical examination, Dr. Rasmussen stated, in pertinent part: "Chest expansion and

[6] Medical reports which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. *See, Harris v. Old Ben Coal Co.*, 23 BLR 1-98 (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123 (Jan. 27, 2006)(en banc).

diaphragmatic excursions normal. Breath sounds normal. No rales, rhonchi, or wheezes." Furthermore, Dr. Rasmussen obtained various clinical tests. In summary, Dr. Rasmussen cited Dr. Patel's x-ray findings of "pneumoconiosis p/q with a profusion of 1/0 throughout all lung zones, as well as Category A large opacity in the right upper lung zone." The electrocardiogram revealed "a left bundle branch block pattern." The ventilatory function studies revealed minimal restrictive impairment." The resting blood gases were "normal." On exercise, "there were multiple premature ventricular contractions during the recovery period." However, the oxygen transfer was "normal and he was not hypoxic." Based upon the foregoing, Dr. Rasmussen concluded:

> These studies indicate very poor exercise tolerance due probably in part to cardiac disease, however, he has normal lung function and retains the pulmonary capacity to perform his last regular coal mine job.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with complicated pneumoconiosis. It is medically reasonable to conclude the patient has complicated coalworkers' pneumoconiosis, Category A, which arose as a consequence of his coal mine employment….
>
> The patient and his physician were informed of the increased premature ventricular contractions following exercise.
>
> The patient has complicated coalworkers' pneumoconiosis, Category A, which is qualifying under Federal Black Lung Guides.

(DX 13).

As stated above, Dr, Richard L. Naeye, who is Board-certified in Anatomic and Clinical Pathology (EX 2), issued a report, dated January 13, 2006 (EX 1). In addition to his own analysis of the biopsy evidence, Dr. Naeye referenced other medical evidence, including an x-ray diagnosis of complicated coal worker's pneumoconiosis; Dr. Imbing's needle biopsy; Dr. Rasmussen's report and the pulmonary function and arterial blood gas results related thereto. In conclusion, Dr. Naeye stated:

> In summary, the X-ray finding likely reflect the presence of multiple, very old coal worker's pneumoconiosis (CWP) macules or micronodules that grew together over a period of many years. If it did arise as a *single* lesion, its composition indicates that it grew to reach its current size over a long period of time. A genuine complicated CWP lesion grows rapidly, with the result that it has a very different composition than the confluent lesions in the present case. A true complicated CWP lesion is far less X-ray dense, with the result that it might have to reach 2.0 cm to produce a 1.0 cm shadow on an X-ray. That is because it is largely comprised of granulation tissue that is far less X-ray dense than the old collagen that largely comprises the lesion in the present case. Thus, the microscopic findings in the present case do not support the diagnosis of complicated coal worker's pneumoconiosis.

I state all of the above with reasonable medical certainty.

(EX 1).[7]

Discussion and Applicable Law

Pneumoconiosis and Causal Relationship

As stated above, Employer stipulated that Claimant has established the presence of *simple* pneumoconiosis pursuant to §718.202(a); and, that the disease arose out of Claimant's coal mine employment (TR 6). Moreover, as discussed below, I find that Claimant has also established the presence of *complicated* pneumoconiosis under §718.304, which arose out of his 21 years of coal mine employment. 20 C.F.R. §718.203.

Total Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. A miner shall be considered totally disabled if the irrebuttable presumption set forth in §718.304 applies. *See* 20 C.F.R. §718.204(b)(1). Furthermore, total disability may also be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, the pulmonary function and/or arterial blood studies are not qualifying under the regulatory standards set forth in Part 718, Appendices B and C, respectively Therefore, Claimant has not established total disability pursuant to §718.204(b)(2)(i) and//or §718.204(b)(2)(ii).

Since there is no evidence which establishes the presence of cor pulmonale with right-sided heart failure, Claimant has also failed to establish total disability pursuant §718.204(b)(2)(iii).

As stated above, there are no physicians' opinions which state that Claimant suffers from a totally disabling pulmonary or respiratory impairment. To the contrary, Dr. Rasmussen expressly stated that Claimant retains the pulmonary capacity to perform his last regular coal mine job. Accordingly, I find that Claimant has not established total disability under §718.204(b)(2)(iv).

[7] Without explanation, Dr. Naeye also noted medical literature relating to pathology standards for coal worker's pneumoconiosis, which he co-authored (EX 1).

Since Claimant has not established total disability under the provisions of §718.204(b)(2)(i)-(iv), the crux of this case rests on whether he is entitled to the irrebuttable presumption of total disability due to pneumoconiosis, as set forth in §718.304.

It is well settled that the determination of whether the miner has complicated pneumoconiosis is a finding of fact, and that I must consider and weigh all relevant evidence. *Melnick v. Consolidation Coal Co.*, 16 BLR 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 BLR 1-683 (1985).

As stated above, unlike the other four B-readers and Board-certified radiologists, Dr. Binns failed to even diagnose simple pneumoconiosis. Therefore, I accord his interpretation little weight. Of the four remaining B-readers and Board-certified radiologists, Drs. Patel and Aycoth reported Category A large opacities; Dr. Miller's written report cites a "3 cm. large opacity," despite his notation of "0" on the ILO classification sheet. Moreover, although Dr. Miller was initially uncertain as to the nature of the large opacity, he ultimately determined that it represents complicated coal worker's pneumoconiosis. Furthermore, even Dr. Gogineni found a "3 cm x 2 cm opacity." Although Dr. Gogineni thought that the large opacity was "suspicious for neoplasm," he suggested a biopsy to address the issue. Accordingly, I find that the preponderance of the credible x-ray evidence, including those by B-readers and Board-certified radiologists, is positive for *complicated* pneumoconiosis. Therefore, I find that Claimant has established the presence of *complicated* pneumoconiosis under §718.304(a).

As outlined above, the biopsy evidence is inconclusive regarding the presence or absence of complicated pneumoconiosis. Dr. Imbing reported findings of fibrosis and anthracotic pigment deposits, and he ruled out malignancy, based upon the needle biopsy performed. However, the tissue sample for the needle biopsy was apparently quite limited. Dr. Naeye's biopsy analysis was even more problematic, because he was not even sure whether the tissue he reviewed was from a lung or lymph node. Dr. Stefanini found abnormalities consistent with the x-ray findings of pneumoconiosis, but could not judge the extent of the process based upon the biopsy tissue alone. Accordingly, I find that the biopsy evidence supports the Employer's stipulation of simple pneumoconiosis, and does not contradict the x-ray findings of complicated pneumoconiosis. Furthermore, to the extent that a malignancy was ruled out, the biopsy evidence supports Dr. Miller's ultimate determination that the large opacity seen on x-ray represents complicated pneumoconiosis, not malignant neoplasm.

Finally, I find that the credible CT scan evidence and other medical opinion evidence also supports a finding of complicated pneumoconiosis. In making this determination, I note Dr. Gogineni found CT scan evidence of a 3 x 2 cm irregular mass in the right upper lobe, which he thought was "suspicious for neoplasm." However, Dr. Gogineni's suspicion was not borne out by the biopsy evidence. In contrast, Dr. Aycoth clearly and unequivocally diagnosed complicated pneumoconiosis based upon the CT scan evidence. Furthermore, his CT scan interpretation is consistent with the preponderance of the x-ray evidence.

The other medical opinion evidence consists of Dr. Rasmussen's report and the non-biopsy portion of Dr. Naeye's report. Although Dr. Rasmussen found no significant pulmonary impairment, he clearly and unequivocally diagnosed pneumoconiosis based primarily upon

Claimant's coal mine employment history and Dr. Patel's positive x-ray reading for complicated pneumoconiosis. In contrast, Dr. Naeye's discussion of the x-ray evidence was somewhat ambiguous. Dr. Naeye stated that it was "likely" that the x-ray findings represent multiple, very old macules or micronodules of pneumoconiosis which grew together over a period of many years. However, Dr. Naeye also noted the possibility that it is a single lesion. More significantly, Dr. Naeye stated that a "true complicated CWP lesion is far less X-ray dense, with the result it might have to reach 2.0 cm to produce a 1.0 cm shadow on an X-ray." However, as discussed above, the credible x-ray evidence, as interpreted by the preponderance of the B-readers and Board-certified radiologists, is positive for complicated pneumoconiosis. Moreover, the overwhelming preponderance of the x-ray evidence establishes the presence of at least one large opacity. Furthermore, the size of the large opacity as found by many of the B-readers and Board-certified radiologists is not simply 1 centimeter in diameter, as required under §718.304(a), but rather 2.0 cm or more. In addition, Dr. Rasmussen's opinion is more consistent with Claimant's significant coal mine employment history and the credible x-ray evidence than Dr. Naeye's opinion. Therefore, taken as a whole, I find that Claimant has established the presence of complicated pneumoconiosis under §718.304.

Total Disability Due to Pneumoconiosis

Since Claimant has established *complicated* pneumoconiosis under §718.304, he is entitled to the irrebuttable presumption that his total disability is due to pneumoconiosis. 20 C.F.R. §718.304.

Conclusion

Having considered the relevant evidence, I find that Claimant has established the presence of *complicated* pneumoconiosis which arose out of his 21 years of coal mine employment. Accordingly, Claimant is eligible for benefits under the Act and regulations.

Commencement of Entitlement to Benefits

The record establishes that Claimant developed complicated pneumoconiosis at an unspecified time between the final denial of the most recent prior claim (*i.e.,* May 30, 2002) (DX 2) and October 13, 2003. Accordingly, a change in conditions has been established pursuant to §725.309.

Section 725.503(b) states, in pertinent part, that where the evidence does not establish the month of onset of total disability due to pneumoconiosis arising out of coal mine employment, benefits shall be payable beginning with the month during which the claim was filed. Therefore, I find that benefits shall commence effective August 1, 2003.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §725.365 and §725.366 of the

regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

It is ordered that the claim of L.F.C. for benefits under the Black Lung Benefits Act is hereby **GRANTED**.

It is further ordered that the Employer, Davidson Mining, Inc., shall pay to the Claimant all benefits to which he is entitled under the Act, augmented by reason of his dependent spouse, as heretofore specified, commencing as of August 1, 2003.

It is further ordered that the Employer, Davidson Mining, Inc., shall reimburse the Secretary of Labor for payments made under the Act to the Claimant, if any, and deduct such amount, as appropriate, from the amount it is ordered to pay under the preceding paragraph above.

A

STEPHEN L. PURCELL
Associate Chief Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).